FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029132

Facility Name: COMMUNITY CARE CENTER

Address: 4314 SOUTH WABASH AVENUE (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: (773) 538-8300 **Fax #** (773) 538-5775

IDPA ID Number: 36-3327511

Date of Initial License for Current Owners: 11/26/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MORRIS ESFORMES

(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,270	89	7,858	20,217	8
9	SNF/PED					9
10	ICF	48,025	192	295	48,512	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,295	281	8,153	68,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.30%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/26/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/26/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 7,858

Medicare Intermediary ADMINISTAR OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	302,114	30,038	11,250	343,402		343,402		343,402			1
2	Food Purchase		290,217		290,217		290,217	(1,756)	288,461			2
3	Housekeeping	207,397	26,915		234,312		234,312		234,312			3
4	Laundry	133,778	17,451	6,457	157,686		157,686	1,493	159,179			4
5	Heat and Other Utilities			157,877	157,877		157,877	442	158,319			5
6	Maintenance	134,820	30,938	106,152	271,910		271,910	1,393	273,303			6
7	Other (specify):*			20,861	20,861		20,861	93	20,954			7
8	**TOTAL General Services**	778,109	395,559	302,597	1,476,265		1,476,265	1,665	1,477,930			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,984,736	89,644	17,334	2,091,714		2,091,714		2,091,714			10
10a	Therapy	13,876			13,876		13,876		13,876			10a
11	Activities		8,037	1,683	9,720		9,720		9,720			11
12	Social Services	233,217		4,903	238,120		238,120		238,120			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,231,829	97,681	29,420	2,358,930		2,358,930		2,358,930			16
	C. General Administration											
17	Administrative	79,291		612,000	691,291		691,291	(247,919)	443,372			17
18	Directors Fees											18
19	Professional Services			53,048	53,048		53,048	11,999	65,047			19
20	Dues, Fees, Subscriptions & Promotions			20,862	20,862		20,862	(4,841)	16,021			20
21	Clerical & General Office Expenses	157,124	25,113	166,285	348,522		348,522	(143,955)	204,567			21
22	Employee Benefits & Payroll Taxes			402,969	402,969		402,969		402,969			22
23	Inservice Training & Education							29	29			23
24	Travel and Seminar			1,655	1,655		1,655		1,655			24
25	Other Admin. Staff Transportation			10,158	10,158		10,158	587	10,745			25
26	Insurance-Prop.Liab.Malpractice			101,247	101,247		101,247	2,833	104,080			26
27	Other (specify):*			702,823	702,823		702,823	(695,170)	7,653			27
28	**TOTAL General Administration**	236,415	25,113	2,071,047	2,332,575		2,332,575	(1,076,437)	1,256,138			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,246,353	518,353	2,403,064	6,167,770		6,167,770	(1,074,772)	5,092,998			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: COMMUNITY CARE CENTER **#0029132** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,250	
	REPAIRS & MAINTENANCE		0	
			0	11,250
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,457	
			0	6,457
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		72,494	
	ELECTRICITY		57,045	
	WATER		26,173	
	CABLE TV - LOBBY		2,165	
			0	157,877
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,230	
	PAINTING & DECORATING		1,751	
	BUILDING REPAIRS		36,364	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		37,622	
	ELEVATOR MAINTENANCE & REPAIR		9,322	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,900	
	FIRE SERVICE		12,963	
			0	
			0	
			0	106,152
7	**OTHER**			
	SCAVENGER		11,333	
	SECURITY SERVICE		9,528	20,861
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500	5,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		2,600	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,590	
	PHARMACY CONSULTANT	XVIII B 39-2	8,544	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT		3,600	
			0	17,334
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,683	
			0	1,683
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,903	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,903
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COMMUNITY CARE CENTER #0029132 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	612,000	612,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,710	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	37,338	
			0	53,048
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,396	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,000	
	LICENSES & PERMITS	XIX F	4,240	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	743	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,753	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,730	20,862
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		4,936	
	OUTSIDE CLERICAL SERVICES		61,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	166	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		25,155	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		75,028	166,285

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	246,267	
	UNEMPLOYMENT COMPENSATION	XIX D	52,858	
	WORKERS COMPENSATION INSURANCI	XIX D	74,718	
	HOSPITALIZATION INSURANCE	XIX D	20,118	
	EMPLOYEE BENEFITS - OTHER	XIX D	500	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	8,508	402,969
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,655	
	TRAVEL	XIX G	0	
			0	
			0	1,655
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,158	10,158
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		101,247	101,247
27	**OTHER**			
	BAD DEBTS	VI 24	702,823	
				702,823

GRAND TOTAL COLUMN 3 OTHER 2,403,064

COMMUNITY CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	290,217	PATIENT MEALS	206187
LESS SALES TAX	(1,756)	ADD EMPLOYEE MEALS	0
NET FOOD	288,461	TOTAL MEALS/YEAR	206187
TOTAL PATIENT CENSUS	68,729	NET FOOD	288461
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	206187
TOTAL PATIENT MEALS	206187	COST PER MEAL	1.4
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number COMMUNITY CARE CENTER #0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			49,207	49,207		49,207	74,713	123,920			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,119	9,119		9,119	347,650	356,769			32
33	Real Estate Taxes							244,824	244,824			33
34	Rent-Facility & Grounds			589,680	589,680		589,680	(589,680)				34
35	Rent-Equipment & Vehicles			39,665	39,665		39,665	5,606	45,271			35
36	Other (specify):* IME, amort software			21,226	21,226		21,226	(15,912)	5,314			36
37	**TOTAL Ownership**			708,897	708,897		708,897	67,201	776,098			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,331	566,874	714,205		714,205		714,205			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		147,331	678,564	825,895		825,895		825,895			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,246,353	665,684	3,790,525	7,702,562		7,702,562	(1,007,571)	6,694,991			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,672	30		9
10	Interest and Other Investment Income	(2,864)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,756)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(166)	21		18
19	Entertainment		20		19
20	Contributions	(2,753)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(702,823)	27		24
25	Fund Raising, Advertising and Promotional	(2,396)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(743)	20		28
29	Other-Attach Schedule	(118,488)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (820,317)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(187,254)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (187,254)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,007,571)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COMMUNITY CARE CENTER

ID# 0029132

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (1,460)	6	1
2	MARKETING SALARY	(42,000)	21	2
3	STAFF DEVELOPMENT	(75,028)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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35				35
36				36
37				37
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(118,488)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,756)	0	0	0	0	0	0	0	0	0	0	(1,756)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,493	0	0	0	0	0	0	0	0	1,493	4
5	Heat and Other Utilities	0	0	0	442	0	0	0	0	0	0	0	442	5
6	Maintenance	(1,460)	0	1,976	877	0	0	0	0	0	0	0	1,393	6
7	Other (specify):*	0	0	44	49	0	0	0	0	0	0	0	93	7
8	TOTAL General Services	(3,216)	0	3,513	1,368	0	0	0	0	0	0	0	1,665	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(255,900)	7,981	0	0	0	0	0	0	0	0	(247,919)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	513	11,414	72	0	0	0	0	0	0	0	11,999	19
20	Fees, Subscriptions & Promotions	(5,892)	0	1,051	0	0	0	0	0	0	0	0	(4,841)	20
21	Clerical & General Office Expenses	(117,194)	7,456	(34,569)	352	0	0	0	0	0	0	0	(143,955)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	29	0	0	0	0	0	0	0	0	29	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	85	502	0	0	0	0	0	0	0	0	587	25
26	Insurance-Prop.Liab.Malpractice	0	211	2,355	267	0	0	0	0	0	0	0	2,833	26
27	Other (specify):*	(702,823)	2,286	5,367	0	0	0	0	0	0	0	0	(695,170)	27
28	TOTAL General Administration	(825,909)	(245,349)	(5,870)	691	0	0	0	0	0	0	0	(1,076,437)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(829,125)	(245,349)	(2,357)	2,059	0	0	0	0	0	0	0	(1,074,772)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	11,672	0	276	1,398	61,367	0	0	0	0	0	0	74,713	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,864)	0	0	2,321	348,193	0	0	0	0	0	0	347,650	32
33	Real Estate Taxes	0	0	0	2,176	242,648	0	0	0	0	0	0	244,824	33
34	Rent-Facility & Grounds	0	0	0	0	(589,680)	0	0	0	0	0	0	(589,680)	34
35	Rent-Equipment & Vehicles	0	428	4,866	312	0	0	0	0	0	0	0	5,606	35
36	Other (specify):*	0	0	0	(15,912)	0	0	0	0	0	0	0	(15,912)	36
37	TOTAL Ownership	8,808	428	5,142	(9,705)	62,528	0	0	0	0	0	0	67,201	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(820,317)	(244,921)	2,785	(7,646)	62,528	0	0	0	0	0	0	(1,007,571)	45

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JOSEF DAVIS	50	SEE ATTACHED SCHEDULE		EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
MORRIS ESFORMES	50	SEE ATTACHED SCHEDULE		EMI ENTERPRISES	LINCOLNWOOD	MGMT. CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
				RSM	LINCOLNWOOD	LANDLORD

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 300,000	EMI ENTERPRISES		$	$ (300,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				44,100	44,100	4
5	V	19	ACCOUNTING FEES				513	513	5
6	V	21	OFFICE EXPENSE				7,456	7,456	6
7	V	25	TRANSPORTATION				85	85	7
8	V	26	INSURANCE				211	211	8
9	V	27	EMPLOYEE BENEFITS				2,286	2,286	9
10	V	30	DEPRECIATION						10
11	V	35	AUTO LEASE				428	428	11
12	V								12
13	V								13
14	Total			$ 300,000			$ 55,079	$ * (244,921)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 61,000	EKS MANAGEMENT, INC.		$	$ (61,000)	15
16	V								16
17	V								17
18	V	4	HOUSEKEEPING SALARIES				1,482	1,482	18
19	V	4	CLEANING SUPPLIES				11	11	19
20	V	6	PAINTERS SALARIES				1,976	1,976	20
21	V	7	SCAVENGER				44	44	21
22	V	17	CFO SALARY				7,981	7,981	22
23	V	19	PROFESSIONAL FEES				11,414	11,414	23
24	V	20	WANT ADS				1,051	1,051	24
25	V	21	OFFICE EXPENSE				26,431	26,431	25
26	V	23	SEMINARS				29	29	26
27	V	25	TRANSPORTATION				502	502	27
28	V	26	INSURANCE				2,355	2,355	28
29	V	27	EMPLOYEE BENEFITS				5,367	5,367	29
30	V	30	DEPRECIATION				276	276	30
31	V	35	EQUIPMENT RENTAL				4,866	4,866	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 61,000			$ 63,785	$ * 2,785	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 15,912	IME REALTY CORP.		$	$ (15,912)	15
16	V								16
17	V								17
18	V	5	UTILITIES				442	442	18
19	V	6	REPAIRS				877	877	19
20	V	7	ALARM SERVICE				49	49	20
21	V	19	PROFESSIONAL FEES				72	72	21
22	V	21	OFFICE EXPENSE				352	352	22
23	V	26	INSURANCE				267	267	23
24	V	30	DEPRECIATION				1,398	1,398	24
25	V	32	INTEREST				2,321	2,321	25
26	V	33	RE TAX				2,176	2,176	26
27	V	35	STORAGE FEES				312	312	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,912			$ 8,266	$ * (7,646)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 589,680	RSM NURSING ASSOCIATES		$	$ (589,680)	15
16	V	30	DEPRECIATION				61,367	61,367	16
17	V	32	INTEREST				348,193	348,193	17
18	V	33	REAL ESTATE TAXES				242,648	242,648	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 589,680			$ 652,208	$ * 62,528	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	OFFICER	ADMINISTRATIV	50.00	SEE			SALARY	$ 44,100	17-7	1
2											2
3	AVRUM WEINFELD	CFO	FINANCE OFFICER		ATTACHED			SALARY	7,981	17-7	3
4											4
5	YOSEF DAVIS	ADMINISTRATIVE	ADMINISTRATIV	50.00	SCHEDULE			MNMGT FEE	300,000	17-3	5
6											6
7	PHILIP ESFORMES	ADMINISTRATIVE	ADMINISTRATIVE					MNMGT FEE	12,000	17-3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 364,081		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARY	PATIENT DAYS	901,761	15	$ 185,000	$ 185,000	68,729	$ 14,100	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725		68,729	513	2
3	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	97,823	79,573	68,729	7,456	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114		68,729	85	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768		68,729	211	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997		68,729	2,286	6
7	17	OFFICER SALARY	DIRECT	1	1	30,000	30,000	1	30,000	7
8	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617		68,729	428	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 359,044	$ 294,573		$ 55,079	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	901,761	15	$ 19,441	$ 19,441	68,729	$ 1,482	1
2	4	CLEANING SUPPLIES	PATIENT DAYS	901,761	15	140		68,729	11	2
3	6	PAINTERS SALARY	PATIENT DAYS	901,761	15	25,925	25,925	68,729	1,976	3
4	7	SCAVENGER	PATIENT DAYS	901,761	15	573		68,729	44	4
5	17	CFO SALARY	PATIENT DAYS	901,761	15	104,714	104,714	68,729	7,981	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759		68,729	11,414	6
7	20	WANT ADS	PATIENT DAYS	901,761	15	13,787		68,729	1,051	7
8	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	346,792	248,929	68,729	26,431	8
9	23	SEMINARS	PATIENT DAYS	901,761	15	380		68,729	29	9
10	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593		68,729	502	10
11	26	INSURANCE	PATIENT DAYS	901,761	15	30,900		68,729	2,355	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423		68,729	5,367	12
13	30	DEPRECIATION	PATIENT DAYS	901,761	15	3,617		68,729	276	13
14	35	EQUIPMENT RENT	PATIENT DAYS	901,761	15	63,848		68,729	4,866	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 836,892	$ 399,009		$ 63,785	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	346,361	15	$ 9,618	$	15,912	$ 442	1
2	6	REPAIRS / MAINT	INCOME	346,361	15	19,083		15,912	877	2
3	7	ALARM SERVICE	INCOME	346,361	15	1,056		15,912	49	3
4	19	PROFESSIONAL FEES	INCOME	346,361	15	1,575		15,912	72	4
5	21	OFFICE EXPENSE	INCOME	346,361	15	7,666		15,912	352	5
6	26	INSURANCE	INCOME	346,361	15	5,806		15,912	267	6
7	30	DEPRECIATION	INCOME	346,361	15	30,446		15,912	1,398	7
8	32	INTEREST	INCOME	346,361	15	50,514		15,912	2,321	8
9	33	RE TAX	INCOME	346,361	15	47,364		15,912	2,176	9
10	35	STORAGE FEES	INCOME	346,361	15	6,785		15,912	312	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 179,913	$		$ 8,266	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RSM NURSING ASSOCIATES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 61,367	$	1	$ 61,367	1
2	32	INTEREST	DIRECT	1	1	348,193		1	348,193	2
3	33	REAL ESTATE TAXES	DIRECT	1	1	242,648		1	242,648	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 652,208	$		$ 652,208	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - IME	X					$	$			$ 2,321	1
2	RSM (DAVIS)	X			$5,000.00		465,000	60,329			7,145	2
3	RSM (EMES LTD PARTN)		X		$975.00		127,440	12,106			1,419	3
4	LASALLE BANK			MORTGAGE	$35,284.00	11/30/01	4,838,255	4,544,971			339,629	4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST	REVOLV			REVOLV	PRIME +	9,119	6
7												7
8												8
9	TOTAL Facility Related				$41,259.00		$ 5,430,695	$ 4,617,406			$ 359,633	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,430,695	$ 4,617,406			$ 359,633	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number COMMUNITY CARE CENTER **#** 0029132 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	247,739	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	253,242	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,503	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	253,242	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	(16,097)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	242,648	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	158,584	8
2001	160,987	9
2002	162,792	10
2003	247,739	11
2004	253,242	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COMMUNITY CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029132

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-03-300-021-0000	NURSING HOME	$ 5,470.70	$ 5,470.70
2.	20-03-300-022-0000	NURSING HOME	$ 60,471.38	$ 60,471.38
3.	20-03-300-023-0000	NURSING HOME	$ 61,189.12	$ 61,189.12
4.	20-03-300-024-0000	NURSING HOME	$ 60,668.57	$ 60,668.57
5.	20-03-300-025-0000	NURSING HOME	$ 59,952.33	$ 59,952.33
6.	20-03-300-026-0000	NURSING HOME	$ 5,489.60	$ 5,489.60
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 253,241.70	$ 253,241.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,088 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 98,640	1
2					2
3	TOTALS			$ 98,640	3

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	204				$ 2,393,321	$ 61,367	39	$ 61,367	$	$ 694,958	4
5											5
6											6
7	IME ALLOCATION			46940		1,344		1,344			7
8											8
	Improvement Type**										
9	VARIOUS			1985	57,320					57,320	9
10	VARIOUS			1986	12,387		15			12,387	10
11	VARIOUS			1987	4,819	153	31.5	153		3,671	11
12	VARIOUS			1988	948	30	31.5	30		663	12
13	VARIOUS			1989	3,644	116	31.5	116		2,344	13
14	VARIOUS			1992	6,146	195	31.5	195		3,069	14
15	VARIOUS			1993	17,589	558	31.5	558		7,613	15
16	UNDERGROUND PLUMBING			1994	1,607	41	39	41		483	16
17	DOORS			1994	630	16	39	16		179	17
18	NURSING STATION			1995	3,000	77	39	77		844	18
19	INSTALLED BATH TUB			1995	8,606	221	39	221		2,362	19
20	ROOF REPAIR			1995	14,900	382	39	382		4,059	20
21	FLOOR COVERING			1995	9,876	253	39	253		2,739	21
22	ROOF WORK			1996	2,200	56	39	56		535	22
23	INSTALL NEW PUMP UNIT, CAR DOOR FOR ELEVATOR			1997	18,215	467	39	467		3,966	23
24	FURNISH & INSTALL BASE, VINYL - 3RD FLOOR			1997	38,100	977	39	977		8,264	24
25	INSTALL NEW MODIFIED ROOF SYSTEM			1997	5,150	132	39	132		1,940	25
26	CHAIN LINK FENCE			1998	3,723	248	15	248		1,767	26
27	FRONT ENTRY DOOR			1998	1,793	46	39	46		351	27
28	GREASE TRAP & TILES			1998	4,300	110	39	110		811	28
29	FIREDAMPERS WITH SLEEVES			1998	4,279	110	39	110		793	29
30	SEAL UP CRACKS AROUND THE BUILDING			1998	3,900	100	39	100		721	30
31	PLUMBING			1999	7,200	185	39	185		1,195	31
32	CEMENT AND ASPHALT WORK			1999	5,900	151	39	151		963	32
33	WALL PAPER			2000	5,155	460	7	422	(38)	5,155	33
34	BOILER			2000	4,537	165	27.5	165		832	34
35	AUDIT RCI GENERATOR			1986	8,181					8,181	35
36	AUDIT SUMP PUMP			1986	414					414	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AUDIT EXHAUST FAN	1986	$ 1,132	$		$	$	$ 1,132	37
38	AUDIT CABINETS	1987	9,462					9,462	38
39	NURSING STATION	2001	24,600	894	27.5	894		4,060	39
40	DOORS	2001	6,867	250	27.5	250		1,135	40
41	TILING	2001	12,958	1,493	5	1,035	(458)	12,958	41
42	CARPETING	2001	6,344	731	5	507	(224)	6,344	42
43	TILING	2002	5,400	196	27.5	196		694	43
44	CARPETING	2002	1,438	116	5	288	172	1,152	44
45	FLOORING	2003	16,348	594	27.5	594		1,510	45
46	WINDOW SCREENS	2004	1,669	111	15	111		167	46
47	FLOOR TILING	2004	23,994	873	27.5	873		1,128	47
48	KITCHEN SINKS	2004	1,772	64	27.5	64		83	48
49	ELEVATOR DOOR	2004	2,200	80	27.5	80		103	49
50	CUBICLE CURTAINS	2004	9,283	1,485	5	1,857	372	3,714	50
51	WALLPAPER & CARPETING	2004	4,005	641	5	801	160	1,602	51
52	WINDOW TREATMENTS	2004	25,216	4,035	5	5,043	1,008	10,086	52
53	WINDOW TREATMENTS	2005	4,920	984	5	197	(787)	197	53
54	CARPETING	2005	2,893	579	5	579		579	54
55	BATHROOM SINKS	2005	2,013	58	27.5	58		58	55
56	COOLING TOWER	2005	30,924	890	27.5	890		890	56
57	BOILER	2005	5,991	172	27.5	172		172	57
58	SHOWER ROOMS	2005	69,820	2,010	27.5	2,010		2,010	58
59	METAL & ROOF FLASHING	2005	5,800	79	27.5	79		79	59
60	ELEVATOR HYDRAULIC PUMP	2005	2,975	40	27.5	40		40	60
61	CERAMIC TILES IN BATHROOMS	2005	16,843	230	27.5	230		230	61
62	PLUMBING	2005	23,850	325	27.5	325		325	62
63	REPLACE CONTROLLER ON SPRINKLER SYSTEN	2005	15,675	214	27.5	214		214	63
64	REPLACE VALVE ON ELEVATOR	2005	6,801	93	27.5	93		93	64
65	BUILT IN WARDROBES	2005	31,594	431	27.5	431		431	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,020,627	$ 85,628		$ 85,833	$ 205	$ 889,227	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 366,412	$ 23,157	$ 36,974	$ 13,817	10 YRS	$ 231,421	71
72	Current Year Purchases	15,666	3,133	783	(2,350)	10 YRS	783	72
73	Fully Depreciated Assets	347,537				10 YRS	347,537	73
74	RELATED PARTIES	380,454	330	330		10 YRS	380,454	74
75	TOTALS	$ 1,110,069	$ 26,620	$ 38,087	$ 11,467		$ 960,195	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,229,336	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 112,248	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,920	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,672	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,849,422	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 33,798 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	03 ECONOLINE WAGON	$ 619.00	$ 5,867	17
18					18
19					19
20					20
21	TOTAL		$ 619.00	$ 5,867	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 261,215	$		$ 261,215	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			22,778			22,778	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			282,881			282,881	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				134,535		134,535	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): lab, feeding	39-8					12,796		12,796	13
14	TOTAL			$		$ 566,874	$ 147,331		$ 714,205	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 287,097	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,250,000))	2,697,485		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	129,050		6
7	Other Prepaid Expenses	9,724		7
8	Accounts Receivable (owners or related parties)	313,358		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,436,714	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	535,905		15
16	Equipment, at Historical Cost	817,768		16
17	Accumulated Depreciation (book methods)	(890,991)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 462,682	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,899,396	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,677,286	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,554		30
31	Accrued Taxes Payable (excluding real estate taxes)	41,360		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,900,200	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,900,200	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,999,196	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,899,396	$	48

*(See instructions.)

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,277,830	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,277,830	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,672,366	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(951,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 721,366	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,999,196	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,077,762	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,077,762	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	313,469	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 313,469	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,864	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,864	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,394,095	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,476,265	31
32	Health Care	2,358,930	32
33	General Administration	2,332,575	33
	B. Capital Expense		
34	Ownership	708,897	34
	C. Ancillary Expense		
35	Special Cost Centers	714,205	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,702,562	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,691,533	41
42	**Income Taxes**	(19,167)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,672,366	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,176	4,436	$ 98,096	$ 22.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,125	12,534	270,805	21.61	3
4	Licensed Practical Nurses	35,205	36,570	684,341	18.71	4
5	CNAs & Orderlies	96,216	105,857	833,141	7.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,141	1,287	13,876	10.78	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	23,198	25,625	233,217	9.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,772	37,118	302,114	8.14	15
16	Dishwashers					16
17	Maintenance Workers	13,504	14,067	134,820	9.58	17
18	Housekeepers	26,875	29,033	207,397	7.14	18
19	Laundry	14,586	16,365	133,778	8.17	19
20	Administrator	2,479	3,799	75,541	19.88	20
21	Assistant Administrator	213	213	3,750	17.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,229	15,736	157,124	9.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,851	4,101	50,205	12.24	31
32	Other Health C: Q.A.	2,209	2,253	48,148	21.37	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	283,779	308,994	$ 3,246,353 *	$ 10.51	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 11,250	1-3	35
36	Medical Director	MONTHLY	5,500	9-3	36
37	Medical Records Consultant	MONTHLY	2,590	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	8,544	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	32	1,683	11-3	44
45	Social Service Consultant	93	4,903	12-3	45
46	Other(specify) Dental Consultant	MONTHLY	3,600	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	125	$ 38,070		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DENISE MARTIN	ADMIN		$ 75,541
KIMBERLY STEELE	ASST ADMIN		3,750
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,291

B. Administrative - Other

Description	Amount
YOSEF DAVIS	$ 300,000
EMI ENTERPRISES	300,000
PHILIP ESFORMES, INC	12,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 612,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		53,048
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 53,048

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 74,718
Unemployment Compensation Insurance		52,858
FICA Taxes		246,267
Employee Health Insurance		20,118
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		500
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		8,508
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 402,969

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check	1,730
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	3,139
TRUST/FRANCHISE/CONTRIB/ETC	2,753
LICENSES & PERMITS	2,250
DUES & SUBSCRIPTIONS	9,000
MGMT CO ALLOCATION	1,051
TRUST/FRANCHISE/CONTRIB/ETC	(2,753)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,396)
Yellow page advertising	(743)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,021

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	1,655
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,655

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2005	$ 1,751	3 YRS	$	$	$	$ 291	$ 585	$ 585	$ 290	$	$
2													
3													
4													
5													
6													
7													
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18													
19													
20	TOTALS		$ 1,751		$	$	$	$ 291	$ 585	$ 585	$ 290	$	$

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8,875**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **3,159** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **111,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees